South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICAID BULLETIN

TO: Providers Indicated

SUBJECT: Medicaid Payments and Third Party Coverage

The Medicaid program makes payments to providers on behalf of beneficiaries for medical services rendered, but only to the extent that the beneficiary has a legal obligation to pay. If the beneficiary does not have a legal obligation to pay, then Medicaid will not make a payment. We have become aware that providers are entering into agreements with third-party payers to accept less than their charge as payment in full for services rendered. In some instances this has resulted in Medicaid overpaying providers.

The Centers for Medicare and Medicaid Services (CMS), in Section 3904.7 of the State Medicaid Manual (CMS Pub. 45), provides instructions to Medicaid agencies when providers have entered into agreements with third party payers to accept less than the amount of charges as payment in full. State Medicaid agencies are instructed not to make payment when the provider bills for the difference between the amount the provider has contracted to accept and the amount of the charges. The State Medicaid Manual states, “Medicaid is intended to make payment only where there is a recipient legal obligation to pay.”

When a beneficiary has third party coverage, including Medicare, there are additional limitations and restrictions placed on providers. Providers may limit the number of Medicaid patients they accept as long as there is no discrimination by age, sex, race, religious preference or national origin, and no violation of the provider’s scope of practice. For example, if your practice sees only children, that is not considered discrimination.

However, federal regulations at 42 C.F.R. 447.20 do not allow a provider to refuse to furnish services covered under the State plan to a Medicaid patient on account of a third party’s potential liability. This means that a provider may not refuse services to a Medicaid beneficiary as a Medicaid patient because the patient has third party coverage, such as Medicare or another insurer. Additionally, 42 C.F.R. 447.20 limits the amount a provider may collect from a Medicaid beneficiary when there is third party coverage. The most a provider can collect from a Medicaid patient is the Medicaid co-payment (cost-sharing) amount. If the provider receives the Medicaid allowed amount in full or is required to accept the third party payment as payment in full, the Medicaid

beneficiary cannot be billed. If the third party payment is less than the Medicaid allowed amount or the amount the provider must accept as payment in full, the provider may collect the difference from the Medicaid beneficiary up to the amount of the Medicaid co-payment. Medicaid will pay any remaining difference to the provider. The provider is limited to the lower of the Medicaid allowed amount or the amount the provider has agreed to accept as payment in full from the third party payer.

These regulations do not mean that a provider cannot limit the number of Medicaid patients they accept. A provider may still limit their practice. However, if a provider has reached their limit of Medicaid patients, the provider must tell the beneficiary prior to providing any services, so that the beneficiary has the opportunity to seek a provider who will accept their Medicaid coverage, along with their third party coverage. A provider cannot base decisions to accept or not accept the beneficiary as a Medicaid patient based on the provider's knowledge of the beneficiary's other coverage.

In an emergency, or if the provider cannot determine that a beneficiary has Medicaid at the time of treatment, the provider must let the beneficiary know if they will be accepted as a Medicaid patient as soon as possible after identifying Medicaid coverage.

Please contact your respective program manager if you have questions regarding this policy. Thank you for your continued support and participation in the South Carolina Medicaid Program.

/S/
Emma Forkner
Director

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